

CERTIFICATE OF DEATH

Reg. Dist. No. 351

7242

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write and give nearest town) <i>Snow Hill</i>		RURAL <i>60 ym</i>		CITY (If outside corporate limits, write and give nearest town) <i>Snow Hill</i>		RURAL <i>X</i>	
TOWN <i>X</i>				TOWN <i>X</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>08</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<i>Elizabeth J. Disharoon</i>				<i>July 22 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OF RACE: <i>White</i>		8. DATE OF BIRTH: <i>July 9-1872</i>		9. AGE last birthday: <i>83/0/13</i>	
		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)				10. IF UNDER 1 YR. Months Days Hours Min.	
		<i>Widowed</i>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>			
11. BIRTHPLACE (State or foreign country): <i>Shawfield, Delaware</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <i>Isaac W. Busby</i>				14. MOTHER'S MAIDEN NAME: <i>Mary J. Swift</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT'S ADDRESS: <i>My James W. Gray, Snow Hill, md</i>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 IMMEDIATE CAUSE (A) <i>Acute Pulmonary Edema</i>						1 day	
ANTECEDENT CAUSE (S) DUE TO (B) <i>Myocardial Insufficiency</i>						1 month	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June</i> , 1951., to <i>July 22, 1955</i> , that I last saw the deceased alive on <i>July 22, 1955</i> and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>John H. LaMar</i>				ADDRESS <i>Snow Hill</i>		DATE SIGNED <i>7/23/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>July 24/55</i>		NAME OF CEMETERY OR CREMATORY <i>Christians Cemetery</i>	
						LOCATION (City, town, or county) (State) <i>Snow Hill, md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>July 24, 55</i>				REGISTRAR'S SIGNATURE <i>Glenn B. Cooper</i>		24. FUNERAL DIRECTOR <i>Wm. H. Brown</i>	
						ADDRESS <i>Snow Hill, md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED

AUG 16 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07237

7239

CERTIFICATE OF DEATH

Reg. Dist. No. 350...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>R.F.D. #2 Box 7</u>				R.F.D. #2 Box 7		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 Home				Pocomoke City, Maryland			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
Rosa Anderson				DEATH: July 30 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F.	C.	Married	April 2, 1893	62	ys.	Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
House wife				Domestic		Maryland	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Levin Wilson				Susan Hargis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				None			
17. INFORMANT & ADDRESS:				James Anderson, Pocomoke City, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A) Exhaustion & Malnutrition						9/23/54	
ANTECEDENT CAUSE (S) (B) Anemia (Sec. to)						to	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Gastric Cancer						7/30/55	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/23, 1954, to 7/30, 1955, that I last saw the deceased alive on 7/30, 1955, and that death occurred at 6 P. M. from the causes and on the date stated above.							
SIGNATURE <u>Paul A. Swanson</u>				ADDRESS		DATE SIGNED	
				M.D. Pocomoke City, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8/3/55		Unionville, Cem.		Pocomoke City, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Aug 3, 1955		Anne E. White		Edgar Whorton-New Church, Va.			

BUREAU V. S.

AUG 5 1955

RECEIVED

7240

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WORCESTER</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
<u>X</u> <u>BERLIN</u>		<u>34 yrs</u>		<u>BERLIN</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>RFD Liberty Town</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Esther Barbara Belovics</u>				<u>July 2 1955</u>			
5. SEX: <u>Fe.</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>April 12, 1904</u>	
				9. AGE last birthday <u>51</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>own home</u>		<u>Pennsylvania</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Alexander Belovics</u>				<u>Barbara Klinko</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give War or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>no</u>		<u>Miss Julia Belovics Berlin, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE				(A) <u>Cerebral vascular accident</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>No known antecedent causes.</u>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Sexual and severe cataplexy</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 25, 1955</u> , to <u>July 2, 1955</u> , that I last saw the deceased alive on <u>July 2, 1955</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert G. Hubbard M.D.</u>				DATE SIGNED <u>7/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/4/55</u>		<u>Evergreen</u>		<u>Berlin Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-4-55</u>		<u>Helen F Hayward</u>		<u>Anna B. Burroughs</u>		<u>Berlin Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1955

BUREAU V. S.

7241

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Newark</u>		<u>80 yrs</u>		<u>Newark</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Leslie Parker Bowen</u>				<u>July 20 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>Oct. 10, 1874</u>	<u>80 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>STORE KEEPER</u>		<u>FRUIT STORE</u>		<u>Newark md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Ira Parker Bowen</u>				<u>Savannah Dydelotte</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>220-10-8396</u>		<u>Mr. Luther Bowen, Newark Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO							
<u>443X</u> <u>Congestive Heart Failure</u>						<u>?</u>	
ANTECEDENT CAUSE (B) DUE TO							
<u>Hypertensive Arterio-sclerotic Cardiovascular Disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/26</u> , 1955, to <u>July 21</u> , 1955, that I last saw the deceased alive on <u>July 16</u> , 1955, and that death occurred at <u>5:45</u> P. M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Thomas L. Jones, M.D.</u>		<u>Snow Hill, Md.</u>		<u>7/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/22/55</u>		<u>Garden of Memories</u>		<u>Newark md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 22, 55</u>		<u>Clayton E. Cooper</u>		<u>Anna A. Burby</u>		<u>Berlin Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 16 1955

RECEIVED

7235

CERTIFICATE OF DEATH

Reg. Dist. No. 350

17240

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
42 TOWN Pocomoke City,		3 years		TOWN Pocomoke City, 42			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100 6 Bridge Street				6 Bridge Street			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
Margaret		V.		Dryden			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Female		White		Married		April 23, 1873	
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
82 yrs.				Maryland		USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
Housewife							
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Henry C. Long				Sarah Carey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				None			
17. INFORMANT & ADDRESS:				Henry M. Dryden, Pocomoke, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
002X IMMEDIATE CAUSE						3 yrs	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						4 yrs	
(A) Arteriosclerotic Heart Disease						1 yr	
(B) Aneurysm Descending Aorta							
(C) Pulmonary Tuberculosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1950, to 7/18, 1955 that I last saw the deceased alive on 7/18, 1955 and that death occurred at 1:30 M, from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED					
Louis E. Flavelynn, M.D.		7/19/55		Pocomoke City, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 21, 1955		Baptist Cemetery		Rehobeth, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 21, 1955		Anne E. White		Henry H. Watson, Pocomoke, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 25 1955

BUREAU V. 1

7248

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Berlin		LENGTH OF STAY (in this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Berlin		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route # 3				STREET ADDRESS (If rural give location) Route # 3			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
Nancy		Purnell		Hammond		7 - 10 19 55	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		A.A.		Widow		8 - - 1873	
9. AGE last birthday:		10. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
81 yrs.		At home		Berlin, Worcester Co., Md.		USA	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:				10b. KIND OF BUSINESS OR INDUSTRY:			
Housewife				At home			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Morris Waters				Sarah Hudson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No		None		Mrs. Marjorie Foreman, Berlin, Md. Rt. # 3			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X							
Immediate cause (a) acute pulmonary edema							12-24h
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Congestive heart failure							72 hrs
(c) Hypertensive Cardio-vascular disease							Several years
Atherosclerosis							Several years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:							20. AUTOPSY ?
19b. MAJOR FINDINGS OF OPERATION							Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
		m.					
22. I hereby certify that I attended the deceased from 5-7-1955 , to 7-9-1955 , that I last saw the deceased alive on 7-9-1955 , and that death occurred at 7-10-55 , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Tracy N. Shuler, Jr. M.D. Berlin, Md.				7-13-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-13-55		Cedar Chapel Cemetery		Newark Worcester Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-13-55		Helen F Hayward		Mary A. Stewart		324 E. Church St., Salisbury, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

JUL 15 1900

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U.S. Bureau of Census

U.S. Bureau of Census

U.S. Bureau of Census

U.S. Bureau of Census

07243

MARYLAND

STATE DEPARTMENT OF HEALTH

7244

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ocean City</u> LENGTH OF STAY (in this place) <u>44 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ocean City</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Rt 2 # 1</u> 1	
3. NAME OF DECEASED (Type or Print) (First) <u>Eleanor</u> (Middle) <u>May</u> (Last) <u>Jarman</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 17, 1895</u>
10a. USUAL OCCUPATION, (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William J. Sinnamow</u>		14. MOTHER'S MAIDEN NAME <u>Virginia E. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Dr. Edward J. Jarman Ocean City Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
157X Immediate cause (a) <u>Carcinoma of pancreas</u>			<u>6 mos</u>
Antecedent cause(s) (b) <u>(260X) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS (c) <u>Diabetes mellitus</u>			<u>8 yrs.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan, 1955, to July 21, 1965, that I last saw the deceased alive on 21 July 1955, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

SIGNATURE H. J. Jarman M.D. (Degree or title) ADDRESS Ocean City, Md DATE SIGNED 23 July 56

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>7/23/55</u>	NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	LOCATION (City, town, or county) <u>Berlin</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG <u>7-25-55</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>James A. Burbage</u>	ADDRESS <u>Berlin Md</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 27 1955

RECEIVED

7245

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>			
X TOWN <u>Pocomoke</u>		<u>39 years</u>		STREET ADDRESS (If rural give location) <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 15 1955</u>			
HARRY R. LUKEHARD							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 1, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Concrete Work</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Lukehard</u>				14. MOTHER'S MAIDEN NAME: <u>Eula Gleason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>213-22-7998</u>		17. INFORMANT & ADDRESS: <u>RFD, Lillian M. Lukehard, Pocomoke, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
2041 IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>							<u>2-3 days</u>
ANTECEDENT CAUSE (B) <u>Anemia, Extremely Severe</u>							<u>2 years (approx)</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Leukemia, Chronic, myeloid -</u>							<u>2 yrs (approx)</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Purpura Secondary to C. Failure</u>							<u>2 weeks</u>
19A. DATE OF OPERATION: <u>✓</u>		19B. MAJOR FINDINGS OF OPERATION: <u>✓</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? <u>✓</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>15 Feb., 1955</u> , to <u>15 July, 1955</u> , that I last saw the deceased alive on <u>15 July, 1955</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. E. Sartorius, Jr.</u>		M. D. <u>Pocomoke, Md.</u>		DATE SIGNED <u>16 July 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>July 16, 1955</u>		REGISTRAR'S SIGNATURE: <u>Anne E. White</u>		24. FUNERAL DIRECTOR <u>Henry H. Watson, Pocomoke, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 18 1955

RECEIVED

7245

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Rural Pocomoke		79 Years		TOWN Rural Pocomoke			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. No. 2				STREET ADDRESS (If rural give location) R.F.D. No. 2			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Annie F. Mason				July 18 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
Female	White	Widowed	February 5, 1876	79 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William Gibbons				Susan Ardis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
No		None		Annie Mae Phillips, Pocomoke, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
153X IMMEDIATE CAUSE (A)						Cardiac Failure	
ANTECEDENT CAUSE (B)						Starvation	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						Large Bowel Neoplasm	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Known since 29 Dec. 1954	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 30, 1946 to 18 July, 1955, that I last saw the deceased alive on July 17, 1955, and that death occurred at 3 P.M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
A. G. Sartorius, Jr.		Pocomoke, Md.				18 July 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 20, 1955		Salem M.E. Cemetery		Pocomoke, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 19, 1955		Anne E. White		Henry H. Watson, Pocomoke, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7236

07246

Reg. Dist. No. 350

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Delaware</u>	COUNTY <u>Brown</u>
CITY (If outside corporate limits write RURAL OR and give nearest town) <u>Worcester City</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Hollandale</u>	
TOWN <u>Worcester</u>		TOWN <u>Hollandale</u> 48X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long Cooper St. York</u>		STREET ADDRESS (If rural, give location) <u>724 N.W. - 3rd Court</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Perkins</u>		<u>July 23</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>June 19/44</u>
		9. AGE last birthday: <u>41</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>House</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Bahama</u>	
13. FATHER'S NAME: <u>(D.K.)</u>		14. MOTHER'S MAIDEN NAME: <u>(?)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>267-24965</u>	
17. INFORMANT & ADDRESS: <u>Helen Cooper - Hollandale Del</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause (a) DUE TO <u>Extra Cerebral Hemorrhage</u>		<u>minutes</u>	
Antecedent cause(s) (b) DUE TO <u>Hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Chronic Ischemic disease</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Excessive heat</u>			
19a. DATE OF OPERATION: <u>7/28/55</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Indoor</u>	
21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>M. E. Astorius</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/28/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>7/29/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Cape Henry</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Del</u>	
DATE REC'D BY LOCAL REG. <u>July 29, 1955</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>	
24. FUNERAL DIRECTOR <u>Edgar A. Harshbarger</u>		ADDRESS <u>One New Church, Va.</u>	

RECEIVED
JUG 1 1955
BUREAU V. 31

MARYLAND STATE DEPARTMENT OF HEALTH

07247

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

7247

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
TOWN <u>Bishop</u>		TOWN <u>Bishop</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) <u>Annie</u> (First) <u>Bell</u> (Middle) <u>Murray</u> (Last)		4. DATE OF DEATH <u>July</u> <u>26</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 31, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>76</u> yrs. If under 1 year (Months) <u>7</u> Days <u>1</u> Hours <u>1</u> Mins. <u>0</u>
11. BIRTHPLACE (State or foreign country) <u>Worcester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Beauchamp</u>		14. MOTHER'S MAIDEN NAME <u>Betty Godfrey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>Hazel Sturtevant</u>	
17. INFORMANT AND ADDRESS <u>Wilmington, Del.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
443X Immediate cause (a) <u>Hypertensive, arteriosclerotic</u>		
Antecedent cause(s) <u>cardiovascular disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>(c) cardiac decompensation</u>		<u>? about 5 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954, to July, 1955, that I last saw the deceased alive on 26 July, 1955, and that death occurred at 9:20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>July 29, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>	LOCATION (City, town, or county) <u>Bethesda, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>July 28-55</u>	REGISTRAR'S SIGNATURE <u>Mrs. Helga Berges</u>	24. FUNERAL DIRECTOR <u>Henry N. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 29 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7248

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 355

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>New Jersey</u>	COUNTY <u>Cape May</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Ocean City</u>	<u>4 hours</u>	TOWN <u>Ocean City</u>	<u>67X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
	<u>Beach at Dorchester St</u>	<u>5737 Astbury Ave</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>FRANK</u>	(Middle) <u>BOONE</u>	(Last) <u>Myers</u>	(Month) <u>JULY</u> (Day) <u>12</u> (Year) <u>1955</u>
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec 5 1888</u>
9. AGE last birthday: <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>	
11. BIRTHPLACE (State or foreign country): <u>Ridley Park Pa</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>George Myers</u>		14. MOTHER'S MAIDEN NAME: <u>See Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If yes, give war or dates of service) <u>✓</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Betty See Myers Ocean City, N.J.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) DUE TO <u>Coronary occlusion massive acute</u>	Antecedent cause(s) (b) DUE TO <u>Arterio Sclerotic C.V.D.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <u>7/15/55</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. J. Hunsicker CHIEF MEDICAL EXAMINER DATE SIGNED July 12 55
M. D. DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>7/15/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Mt. Hope</u>	LOCATION (City, town, or county) (State): <u>Delaware Co. Pa.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: <u>7/12-55</u>	24. FUNERAL DIRECTOR: <u>Helen F Hayward</u>	ADDRESS: <u>Bruna A. Bambergs Berlin Md</u>	

BUREAU V. A.

15 1955

RECEIVED

7249

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. **353**

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Selbyville, Del.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Selbyville, Del. (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Leo</u> (First) <u>Strasser</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>July 30</u> (Month) <u>1955</u> (Year)	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>1885</u>
9. AGE last birthday <u>70</u> yrs.		If under 1 year: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>See Deliverer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Palmer Hall, Selbyville, Del.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary thrombosis, acute,</u>			<u>minutes</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Recurrent, see 1 Coronary Heart Disease</u>			<u>4-5 yrs</u>
(c) <u>Atherosclerosis Generalized</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE) <u>Berlin, R.F.D. 1 Worcester Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>Samuel A. Rabbin M.D. Dyr Med Exam.</u> (Degree or title) ADDRESS <u>Berlin, Md</u> DATE SIGNED <u>8/1/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Aug. 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Old Fellows</u>		LOCATION (City, town, or county) (State) <u>Bishopville Md</u>	
DATE REC'D BY LOCAL REG. <u>Aug. 1, 1955</u>		REGISTRAR'S SIGNATURE <u>Hilda Ryan Bergin</u>	
24. FUNERAL DIRECTOR <u>Henry H. Watson</u>		ADDRESS <u>Rockville City Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 3 1955

BUREAU V. S.

7250

07250

Item 21 Film 8-19-55 smg

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 350

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
X TOWN <u>Pocomoke Md Rural</u>	<u>years</u>	TOWN <u>Pocomoke (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		<u>Back yard</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Edward</u>	(Middle) <u>Clifford</u>	(Last) <u>Sturgis</u>	(Month) <u>July</u> (Day) <u>10</u> (Year) <u>1955</u>
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>C</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>		8. DATE OF BIRTH: <u>7/4/55</u>	
9. AGE last birthday: <u>6</u> yrs.		10. IF UNDER 1 YEAR: <u>6</u> Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Working baby</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE: <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Geater Deuhl</u>		14. MOTHER'S MAIDEN NAME: <u>Vergie Sturgis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or rank.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY No.: <u>-</u>	
17. INFORMANT & ADDRESS: <u>Vergie Sturgis Mother</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Asphyxia</u>		<u>Probably accidental</u>	
DUE TO			
Antecedent cause(s) (b) <u>Smothered</u>			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION: <u>8/10/55</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF CONTRIBUTING CAUSE OF DEATH: <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Home</u>	
21c. (City or town) <u>Pocomoke City</u> (County) <u>Worcester</u> (State) <u>Md.</u>			
21d. TIME (Month) <u>July</u> (Day) <u>9th</u> (Year) <u>1955</u> (Hour) <u>to 10th M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Child found over covered in a hot stuffy room</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>V.E. Antonis</u>		M. D. <u>7/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>7/10/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Worcester</u>		LOCATION (City, town, or county) <u>Pocomoke, Md</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG <u>July 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>	
24. FUNERAL DIRECTOR <u>Edgar Roberts</u>		ADDRESS <u>New Church, Md</u>	

VS. A15A-5-53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 18 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07251
7237 Items 2,7, Film 184 7-25-55 et
CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 42 TOWN Pocomoke		LENGTH OF STAY (in this place) 8 Months		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke Stokton- Rural X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Belden Restorium				STREET ADDRESS (If rural give location) Belden Restorium -----			
3. NAME OF DECEASED: (First) (Middle) (Last) Alice M. Tarr				4. DATE (Month) (Day) (Year) OF DEATH: July 17 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: November 18, 1876	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William J. Hancock				14. MOTHER'S MAIDEN NAME: Alice Bonnevillie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Lester N. Lang, Pocomoke, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Hemorrhage, upper G-I, massive						minutes only	
ANTECEDENT CAUSE (B) Undetermined, Cause Acute - Poss. Malignant						Undet.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Cardiac Failure Grade 2						Several months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Obesity, Very marked approx 100 lbs						many months	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION: Tuberculosis, Pulmonary, arrested 2 years					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While Not while at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from December, 1952, to 17 July, 1953, that I last saw the deceased alive on 16 July, 1953, and that death occurred at 1:04 A.M. from the causes and on the date stated above.							
SIGNATURE N.E. Sartorius, Jr.		M. D. Pocomoke, Md.		DATE SIGNED 18 July '55.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 20, 1955		NAME OF CEMETERY OR CREMATORY Goodwill M.E. Cementary		LOCATION (City, town, or county) Pocomoke, Md.	
DATE REC'D BY LOCAL REGISTRAR July 19, 1955		REGISTRAR'S SIGNATURE Anne E. White		24. FUNERAL DIRECTOR Henry H. Watson, Pocomoke, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 21 1955

RECEIVED

7238

CERTIFICATE OF DEATH

Reg. Dist. No. 350

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Accomack</u>		STATE <u>Virginia</u> COUNTY <u>Accomack</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mears Va.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Clark Ave</u>		LENGTH OF STAY (in this place) <u>7 months</u>		STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Sevell</u> (Middle) <u>—</u> (Last) <u>Taylor</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 21 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec 25 1872</u>	9. AGE last birthday: <u>82</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Coun</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Oliver Taylor</u>				14. MOTHER'S MAIDEN NAME: <u>Mary C. Taylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service): <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs William E Ross</u>			
18. MEDICAL CERTIFICATION				INTERNAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>422.1</u>				(A) <u>Cerebral Hemorrhage</u> <u>2 days</u>			
ANTECEDENT CAUSE (S):				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Arteriosclerotic Cardio Vase</u> <u>4 yrs</u>			
				(C) <u>Senility</u> <u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1955</u> to <u>7/21, 1955</u> that I last saw the deceased alive on <u>7/21, 1955</u> and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Louis E. Howelton</u>		M.D. <u>Paramack City</u>		DATE SIGNED <u>7/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 24/55</u>		<u>Bloxham Cem Bloxham</u>		<u>Accomack Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 24, 1955</u>		<u>Anne E. White</u>		<u>Henry G. Watson</u>		<u>Paramack Md.</u>	

RECEIVED

JUL 26 1955

BUREAU V. S.

VS. A15 — 10 - 53

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MARGIN RESERVED FOR BINDING

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PLEASE TYPE OR TYPE IN PLAINLY WITH LINEATING INK. Supply every item of information carefully. m.

7251

CERTIFICATE OF DEATH

Reg. Dist. No. 351....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WORCESTER</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>NEWARK</u>				<u>NEWARK</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>ALINE DENNIS TOWNSEND</u>				<u>JULY 23 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>OCT. 25, 1878</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE WIFE</u>		<u>OWN HOME</u>		<u>NEWARK MD</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>CLAYTON DENNIS</u>				<u>BETTY JONES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>217-05-7193</u>		<u>Mrs. HAZEL TAYLOR, NEWARK MD</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>442X ACUTE PULMONARY EDEMA</u>						<u>2 DAYS</u>	
ANTECEDENT CAUSE (B) <u>HYPERTENSIVE CARDIOVASCULAR RENAL SYNDROME</u>						<u>10 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>June</u> , 195 <u>2</u> , to <u>July 23, 1955</u> , that I last saw the deceased alive on <u>July 22</u> , 195 <u>5</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Tobias H. Laman</u>		<u>5000 Hill</u>		<u>7-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/25/55</u>		<u>BOWEN</u>		<u>NEWARK MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 25, 55</u>		<u>Elwyn G. Cooper</u>		<u>Anna A. Burdette Berlin</u>		<u>MD</u>	

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 16 1955

BUREAU V. S.

7252

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN West Ocean City		LENGTH OF STAY (in this place) 15 yrs.		TOWN West Ocean City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) James (Middle) (Last) Tynes				4. DATE OF DEATH: (Month) 7 - (Day) 11 - (Year) 19 55			
5. SEX: Male		6. COLOR OR RACE: A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: About 1886	
9. AGE last birthday: About 69 yrs.		10. BIRTHPLACE (State or foreign country): Smithfield, Virginia		11. CITIZEN OF WHAT COUNTRY? USA			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer				10b. KIND OF BUSINESS OR INDUSTRY: Farming			
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Nalia Mitchell, West Ocean City, Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
493X Immediate cause (a) fractured						5 days	
Antecedent causes (s) (b) fractured							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) fractured							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. Arterio sclerotic CVD with heart failure							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 5, 1955, to July 11, 1955, that I last saw the deceased alive on July 9, 1955, and that death occurred at Ocean City, Md. from the causes and on the date stated above.							
SIGNATURE James Tynes		(Degree title) MD		ADDRESS Ocean City, Md.		DATE SIGNED July 11 1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Buried		7-12-55		Evergreen Cemetery		Berlin, Worcester Co., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR			
7-12-55		Helen F. Hayward		Mary A. Stewart, 324 E. Church St., Salisbury, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Worcester

Worcester

West Coast City

18 Dec.

West Coast City

At home

7 - 11 - 55

Tynes

Tynes

About 98

About 1988

Single

A.A.

Male

UTA

Switzerland, Virginia

Switzerland

Switzerland

Unknown

Unknown

Mrs. Helen Hittner, West Coast City, Mo.

None

No

No

BUREAU V. S.

JUL 15 1955

RECEIVED

Worcester, Mo.

Worcester, Mo.

7-18-55

Switzerland